(3) Tier three includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 50% but less than 60%.

(4) Tier four includes all hospitals deemed to be disproportionate share hospitals based on a low-income utilization rate greater than or equal to 60% .

D. Distribution of funds within each hospital tier

The funds available in a tier are distributed among hospitals in that tier according to the payment formulas described below. Hospitals will be distributed a payment amount based on the lesser of their uncompensated care costs or their disproportionate share payment. Uncompensated care costs are defined as total inpatient allowable costs less insurance revenues, self-pay revenues, total Medicaid revenues and uncompensated care costs rendered to patients with insurance for the service provided. Each hospital's disproportionate share payment is calculated on a tier-specific basis as follows:

$$\frac{\text{Hospital specific uncompensated care Costs}}{\text{sum of uncompensated care costs for all hospitals in the tier}} \times \text{Disproportionate share funds available for distribution in the tier}$$

(1) Funds available for distribution by tier.

(a) Tier 1. A maximum of 5% of the disproportionate share funds will be distributed to the hospitals in tier one.

If no hospitals fall into tier one, or all funds are not distributed, then undistributed funds from tier one will be added to the funds available for distribution in tier four.

(b) Tier 2. A maximum of 25% of the disproportionate share funds will be distributed to hospitals in tier two.

If no hospitals fall into tier two, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(c) Tier 3. A maximum of 45% of the disproportionate share funds will be distributed to hospitals in tier three.

If no hospitals fall into tier three, or all funds are not distributed, then undistributed funds will be added to the funds available for distribution in tier four.

(d) Tier 4. A minimum of 40% of the disproportionate share funds will be distributed to hospitals in tier four.

(2) Payment distribution

Each hospital will be distributed a payment amount based on the lesser of their:

(a) Uncompensated care costs; or

(b) Disproportionate share payment amount

E. Disproportionate share funds

The maximum amount of disproportionate share funds available for distribution to psychiatric hospitals will be determined by subtracting the funds distributed in accordance with rule 5101:3-2-09 of the administrative code from the state's disproportionate share limit as described in subparagraph (f) of section 1923 of the Social Security Act, 49 Stat. 620 (1935), 42 USC 1396-r-4 (f), as amended.

ATTACHMENT 4.19-A

5101:3-2-09 **Payment policies for disproportionate share and indigent care adjustments for hospital services.**

This rule is applicable for ~~the~~ each program year ~~that ends in calendar year 2003,~~ for all medicaid-participating providers of hospital services included in the definition of "hospital" as described under section 5112.01 of the Revised Code.

(A) Definitions.

(1) "Total medicaid costs" for each hospital means the sum of the amounts reported in JFS 02930, schedule H, section I, columns 1 and 3, line 1 and section II, column 1, line 13.

(2) "Total medicaid managed care plan inpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 3, line 101.

(3) "Total medicaid managed care plan outpatient costs" for each hospital means the amount on JFS 02930 schedule I, column 5, line 101.

(4) "Total Title V costs" for each hospital means the amount on JFS 02930, schedule H, section I, column 2, line 1 and section II, column 2, ~~line 13.~~ line 12.

(5) "Total inpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 8.

(6) "Total inpatient uncompensated care costs under one hundred percent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 9.

(7) "Total inpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930, schedule F, column 5, line 10.

(8) "Total outpatient disability assistance medical costs" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 12.

(9) "Total outpatient uncompensated care costs under one hundred per cent" for each hospital means the amount on the JFS 02930, schedule F, columns 4 and 5, line 13.

(10) "Total outpatient uncompensated care costs above one hundred per cent without insurance" for each hospital means the amount on the JFS 02930,

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schedule F, column 5, line 14.

(11) "Total disability assistance medical costs" means the sum of total inpatient disability assistance costs as described in paragraph (A)(5) of this rule, and total outpatient disability assistance costs as described in paragraph (A)(8) of this rule.

(12) "Total uncompensated care costs under one hundred per cent" means the sum of total inpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(6) of this rule, and total outpatient uncompensated care costs under one hundred per cent as described in paragraph (A)(9) of this rule.

(13) "Total uncompensated care costs above one hundred per cent without insurance" means the sum of total inpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(7) of this rule, and total outpatient uncompensated care costs above one hundred per cent without insurance as described in paragraph (A)(10) of this rule.

(14) "Managed care plan days" (MCP days) means for each hospital the amount on the JFS 02930, schedule I, column 1, line 103.

(15) "High federal disproportionate share hospital" means a hospital with a ratio of total medicaid days plus MCP days to total facility days greater than the statewide mean ratio of total medicaid days to total facility days plus one standard deviation.

(16) "Total medicaid payments" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, column 1, lines 8, 19, 24, and 25, and column 3, lines 8 and 24, minus the amounts on schedule H, column 1, lines 6 and 18.

(17) "Total medicaid days" means for each hospital the amount on the JFS 02930, schedule C, column 6, line 35 and column 10, line 35.

(18) "Total facility days" means for each hospital the amount reported on the JFS 02930, schedule C, column 4, line 35.

(19) "Medicaid inpatient payment-to-cost ratio" for each hospital means the sum of the amounts reported on the JFS 02930, schedule H, columns 1 and 3, line 8, less the amount described in paragraph (A)(32) of this rule, divided by the sum of the amounts reported on the JFS 02930, schedule H, section I,

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columns 1 and 3, line 1.

(20) "Medicaid outpatient payment-to-cost ratio" for each hospital means the amount reported on the JFS 02930, schedule H, column 1, line 19, divided by the amount reported on the JFS 02930, schedule H, section II, column 1, line 13.

(21) "Total medicaid managed care plan (MCP) costs" means the actual cost to the hospital of care rendered to medical assistance recipients enrolled in a managed care plan that has entered into a contract with the department of job and family services and is the amount on JFS 02930, schedule I, column 3, line 101 and column 5, line 101.

In the event the hospital cannot identify the costs associated with recipients enrolled in a health maintenance organization, the department shall add the payments made or charges incurred for the recipient, as reported by the health maintenance organization and verified by the department, to total medicaid managed care costs.

(22) "Medicaid managed care plan (MCP) inpatient payments" for each hospital means the amount defined in paragraph (A)(2) of this rule multiplied by the ratio calculated in paragraph (A)(19) of this rule; or, actual certified MCP payment data reported to the department by hospitals, as described in paragraphs (A)(30) and (A)(31) of this rule.

(23) "Medicaid managed care plan (MCP) outpatient payments" for each hospital means the amount defined in paragraph (A)(3) of this rule multiplied by the ratio calculated in paragraph (A)(20) of this rule; or, actual certified MCP payment data reported to the department by hospitals, as described in paragraphs (A)(30) and (A)(31) of this rule.

(24) "Total medicaid managed care plan (MCP) payments" for each hospital is the sum of the amount calculated in paragraph (A)(22) of this rule, and the amount calculated in paragraph (A)(23) of this rule.

(25) "Adjusted total facility costs" means the amount described in paragraph (A) of rule 5101:3-2-08 of the Administrative Code.

(26) "Rural hospital" means a hospital that is classified as a rural hospital by the centers for medicare and medicaid services.

(27) "Critical Access Hospital (CAH)" means a hospital that is certified as a critical access hospital by the centers for medicare and medicaid services, and that

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has notified the Ohio department of health and the Ohio department of job and family services of such certification. Beginning in the program year that ends in calendar year 2004, the Ohio department of job and family services must receive notification of critical access hospital certification by the first day of October, the start of the program year, in order for the hospital to be considered a critical access hospital for disproportionate share payment purposes.

(28) "Hospital-specific disproportionate share limit" means the limit on disproportionate share and indigent care payments made to hospitals as defined in paragraph (D) of rule 5101:3-2-07.5 of the Administrative Code.

(29) "Children's Hospitals" are those hospitals that meet the definition in paragraph (A)(2) of rule 5101:3-2-07.2 of the Administrative Code

(30) "Certified MCP Payment data" means that an independent party, a certified public accountant, has successfully verified the medicaid MCP payment data that will be reported to ODJFS.

(31) "Medicaid managed care plan payment proxy calculation verification" means that each hospital for which the proxy calculation creates a negative medicaid managed care shortfall, shall have the opportunity to submit additional, certified MCP payment data to the department in order to accurately reflect MCP shortfall.

(32) "Other Medicaid payments" for each hospital means the amount reported in JFS 02930, schedule H, section I, column 1, line 5.

(33) "Total Program Amount" means the sum of the amounts in paragraphs (J)(2) and (J)(3) of this rule.

(B) Applicability.

The requirements of this rule apply as long as the United States center for medicare and medicaid services determines that the assessment imposed under section 5112.06 of the Revised Code is a permissible health care related tax. Whenever the department of job and family services is informed that the assessment is an impermissible health care-related tax, the department shall promptly refund to each hospital the amount of money currently in the hospital care assurance program fund that has been paid by the hospital, plus any investment earnings on that amount.

(C) Source data for calculations.

(1) The calculations described in this rule will be based on cost-reporting data

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described in ~~rule 5101:3-2-23~~ paragraph (B)(1) of rule 5101:3-2-08 of the Administrative Code ~~which reflect the hospital's cost reporting period ending in state fiscal year 2002~~.

(2) For new hospitals, the first available cost report filed with the department in accordance with rule 5101:3-2-23 of the Administrative Code will be used until a cost report which meets the requirements of this paragraph is available. If, for a new hospital, there is no available or valid cost report filed with the department, the hospital will be excluded until valid data is available. For hospitals which have changed ownership, the cost reporting data filed by the previous owner which reflects that hospital's completed interim settled medicaid cost report and the cost reporting data filed by the new owner which reflects that hospital's completed interim settled medicaid cost report, will be combined and annualized by the department to reflect one full year of operation. If there is no available or valid cost report from the previous owner, the department shall annualize the cost report from the new owner to reflect one full year of operation. Cost reports for hospitals involved in mergers during the program year that result in the hospitals using one provider number will be combined and annualized by the department to reflect one full year of operation.

(3) Closed hospitals with unique medicaid provider numbers.

For a hospital facility, identifiable to a unique medicaid provider number, that closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data used shall be adjusted to reflect the portion of the year the hospital was open during the current program year. That partial year data shall be used to determine the distribution to that closed hospital. The difference between the closed hospital's distribution based on the full year cost report and the partial year cost report shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

For a hospital facility identifiable to a unique medicaid provider number that closed during the immediate prior program year, the cost report data shall be used to determine the distribution that would have been made to that closed hospital. This amount shall be redistributed to the remaining hospitals in accordance with paragraph (G) of this rule.

(4) Replacement hospital facilities.

If a new hospital facility is opened for the purpose of replacing an existing (original) hospital facility identifiable to a unique medicaid provider number and the original facility closes during the program year defined in paragraph (A) of rule 5101:3-2-08 of the Administrative Code, the cost report data from

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the original facility shall be used to determine the distribution to the new replacement facility if the following conditions are met: (a) both facilities have the same ownership, (b) there is appropriate evidence to indicate that the new facility was constructed to replace the original facility, (c) the new replacement facility is so located as to serve essentially the same population as the original facility, and (d) the new replacement facility has not filed a cost report for the current program year.

For a replacement hospital facility that opened in the immediate prior program year, the distribution for that facility will be based on the cost report data for that facility and the cost report data for the original facility, combined and annualized by the department to reflect one full year of operation.

(5) Cost report data used in the calculations described in this rule will be the cost report data described in this paragraph subject to any adjustments made upon departmental review prior to final determination which is completed each year and subject to the provisions of rule 5101:3-2-08 of the Administrative Code.

(D) Determination of indigent care pool.

(1) The "indigent care pool" means the sum of the following:

(a) The total assessments paid by all hospitals less the assessments deposited into the legislative budget services fund and the health care services administration fund described in rule 5101:3-2-08 of the Administrative Code.

(b) The total amount of intergovernmental transfers required to be made by governmental hospitals less the amount of transfers deposited into the legislative budget services fund and the health care services administration fund described in rule 5101:3-2-08 of the Administrative Code.

(c) The total amount of federal matching funds that will be made available in the same program year as a result of payments made under paragraph (J)(4) of this rule.

(E) Distribution of funds through the indigent care payment pools

The funds are distributed among the hospitals according to indigent care payment pools described in paragraphs (E)(1) to (E)(3) of this rule.

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(1) Hospitals meeting the high federal disproportionate share hospital definition described in paragraph (A)(15) of this rule shall receive funds from the high federal disproportionate share indigent care payment pool.

(a) For each hospital which meets the high federal disproportionate share definition, calculate the ratio of the hospital's total medicaid costs and total medicaid MCP costs to the sum of total medicaid costs and total medicaid MCP costs for all hospitals which meet the high federal disproportionate share definition.

(b) For each hospital which meets the high federal disproportionate share definition, multiply the ratio calculated in paragraph (E)(1)(a) of this rule by $41,441,812.~~00~~. This amount is the hospital's federal high disproportionate share hospital payment amount.

(2) Hospitals shall receive funds from the medicaid indigent care payment pool.

(a) For each hospital, calculate medicaid shortfall by subtracting from total medicaid costs, as defined in paragraph (A)(1) of this rule, the total medicaid payments, as defined in paragraph (A)(16) of this rule. For hospitals with a negative medicaid shortfall, the medicaid shortfall amount is equal to zero.

(b) For each hospital, calculate medicaid MCP inpatient shortfall by subtracting from the total medicaid managed care plan inpatient costs, as defined in paragraph (A)(2) of this rule, medicaid MCP inpatient payments, as defined in paragraph (A)(22) of this rule. ~~For hospitals with a negative medicaid MCP inpatient shortfall, the medicaid MCP inpatient shortfall amount is equal to zero~~.

(c) For each hospital, calculate medicaid MCP outpatient shortfall by subtracting from the total medicaid managed care plan outpatient costs, as defined in paragraph (A)(3) of this rule, medicaid MCP outpatient payments, as defined in paragraph (A)(23) of this rule. ~~For hospitals with a negative medicaid MCP outpatient shortfall, the medicaid MCP outpatient shortfall amount is equal to zero~~.

(d) For each hospital, calculate medicaid MCP shortfall as the sum of the amount calculated in paragraph (E)(2)(b) of this rule, and the amount calculated in paragraph (E)(2)(c) of this rule.

(e) For each hospital, sum the hospital's medicaid shortfall as calculated in

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paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(f) For all hospitals, sum all hospitals medicaid shortfall as calculated in paragraph (E)(2)(a) of this rule, medicaid MCP shortfall as calculated in paragraph (E)(2)(d) of this rule, total medicaid costs, total medicaid MCP costs, and total Title V costs.

(g) For each hospital, calculate the ratio of the amount in paragraph (E)(2)(e) of this rule to the amount in paragraph (E)(2)(f) of this rule.

(h) For each hospital, multiply the ratio calculated in paragraph (E)(2)(g) of this rule by ~~$76,009,499~~$90,810,067 to determine each hospital's medicaid indigent care payment amount subject to the following limitations:~~.~~

(i) If the sum of a hospital's payment amounts calculated in paragraph (E)(1) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's medicaid indigent care payment pool amount is equal to zero.

(ii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the amount in (E)(2)(h) of this rule.

(iii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2)(h) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, then the payment is equal to the difference between the amount calculated in paragraph (A)(28) of this rule and the amount calculated in paragraph (E)(1) of this rule.

(iv) For all hospitals, sum the amounts calcuated in paragraph (E)(2)(h) of this rule. This amount is the hospital's medicaid indigent payment amount.

(3) Hospitals shall receive funds from the disability assistance medical and uncompensated care indigent care payment pool.

(a) For each hospital, sum total disability assistance medical costs defined in

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paragraph (A)(11) of this rule and total uncompensated care costs under one hundred per cent defined in paragraph (A)(12) of this rule.

(b) Each hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(a) of this rule, subject to the following limitations:

(i) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule is greater than or equal to its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule, the hospital's disability assistance medical and uncompensated care under one hundred per cent payment amount is equal to zero.

(ii) If the sum of a hospital's payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(a) of this rule is less than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule; the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the amount calculated in paragraph (E)(3)(a) of this rule.

(iii) If a hospital does not meet the condition described in paragraph (E)(3)(b)(i) of this rule, and the sum of its payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule and the amount calculated in paragraph (E)(3)(a) of this rule is greater than its hospital-specific disproportionate share limit defined in paragraph (A)(28) of this rule; the hospital's disability medical and uncompensated care under one hundred per cent payment amount is equal to the difference between the hospital's disproportionate share limit and the sum of the payment amounts calculated in paragraphs (E)(1) and (E)(2) of this rule.

(c) For all hospitals, sum the amounts calculated in paragraph (E)(3)(b) of this rule.

(d) For each hospital except those meeting either condition described in paragraph (E)(3)(b)(i) or (E)(3)(b)(iii) of this rule, multiply a factor of 0.30 by the hospital's total uncompensated care costs above one hundred percent without insurance, as described in paragraph (A)(13) of this rule. For hospitals meeting the conditions described in paragraph (E)(3)(b)(i) or (E)(3)(b)(iii) of this rule, multiply the hospital's total

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